CITY OF CLEVELAND
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH

BUREAU OF VITAL STATISTICS

601 Lakeside Avenue, Room 122
Cleveland, Ohio 44114

APPLICATION FOR CERTIFIED COPY OF BIRTH RECORD

IMPORTANT

Remit Fee of Eleven Dollars ($11.00) for each copy requested

DIRECTIONS: FILL IN ALL BLANKS ABOVE THE DOTTED LINE. PLEASE PRINT CLEARLY.

INFORMATION ABOUT PERSON WHOSE BIRTH CERTIFICATE IS REQUESTED (Type or Print)				
Name at Birth	First	Middle		Last
Date of Birth	Month	Day	Year	Age (at last birthday)
Place of Birth	City	State	Hospital or Home	
Full name of father	First	Middle		Last
Mother's maiden name (Name before marriage)	First	Middle		Last

Name of person making request (type or print)

No. of copies requested ☐

Address

Signature _____

City, State, Zip

Home Phone

Business Phone

Have any corrections or changes ever been made to the certificate
Yes No

For Office Use only

Type of credit card _____

Name: _____

Card #: _____

Exp. date: _____

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